Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005106	A. BUILDING: _____ B. WING _____	C 08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL	901 MACARTHUR BLVD MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State hospital complaint. Complaint Number: IN00133222 Substantiated; no deficiencies related to allegations are cited Facility Number: 005106 Survey Date: 08/26/13 Surveyor: Carol Laughlin, RN Public Health Nurse Surveyor Community Hospital is in compliance with 410 IAC 15-1.5-4, Medical record services, 15-1.5-5, Medical staff and 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 08/29/13	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE